Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 003932 | A. BUILDING: _____ B. WING _____ | 08/13/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST VINCENT CARMEL HOSPITAL INC | 13500 N MERIDIAN ST CARMEL, IN 46032 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 000 | INITIAL COMMENTS<br><br>Please note:<br>Surveyor: 33212<br><br>Facility #: 150157<br>Type of survey: State licensure Off Site JCAHO Accreditation Survey<br><br>Date of JCAHO on site Hospital full Survey: April 16-18, 2013<br><br>Date of ISDH off site survey: August 13, 2013.<br><br>Reviewer/surveyor Nancy Otten, RN, PHNS<br><br>Based on review of the JCAHO Accreditation Report, it has been determined that St. Vincent Carmel Hospital meets the requirements for Hospital licensure in Indiana. | A 000 | | |

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE